Date: [Date]

To: [Employer Name/Company Name]
Attention: [Human Resources/Manager Name]

RE: Return to Work Medical Clearance
Patient Name: [Patient Full Name]
Date of Birth: [DOB]

To Whom It May Concern,

This letter serves to provide a medical update regarding [Patient Name], who has been undergoing neurological rehabilitation following [Nature of Condition/Injury].

The patient is medically cleared to return to work effective **[Start Date]**. However, this clearance is contingent upon the patient's continued participation in outpatient therapy services to ensure a safe and sustainable transition.

Work Status:

- [ ] Full Duty (No restrictions)
- [ ] Modified Duty (As outlined below)
- [ ] Part-time/Reduced Hours: [Specify hours per week]

Outpatient Therapy Schedule:
The patient is required to attend therapy sessions [Number] times per week. We request that the employer allow flexibility for the patient to attend these essential medical appointments.

Specific Work Accommodations (if applicable):
[List specific restrictions such as: No heavy lifting, frequent rest breaks, limited screen time, or cognitive pacing.]

We will re-evaluate the patient's status on [Follow-up Date] to determine if modifications to this plan are necessary. If you have any questions regarding these recommendations, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Title]
[Facility/Clinic Name]
[Contact Information]